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letter to the editor

Response to: "Family Medicine and Internal Medicine: Let Our Powers Combine!"

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To the Editor:

The primary care shortage in the United States is alarming. In his recent letter,[1] Dr Snellings has suggested that the root of the problem is essentially the inability to recruit medical students into family medicine residency programs, and he proposed that returning to a combined family medicine/internal-medicine residency program model from the late 1990s would increase the primary care provider (PCP) pipeline. While reinvigorating this model may be worth exploring, this proposed solution has left me with more questions than hope.

I am reluctant to believe this solution will resolve the PCP shortage without first understanding the causes of the problem. For the medical profession in general, the number of active residents and fellows is on the rise, as is the number of medical students, growing almost 37% in the past 2 decades.[2] Despite an increase in incoming physicians, current physicians are retiring early or leaving the profession entirely, for a variety of reasons including burnout, falling reimbursement rates, legislative overreach into medical care, and the criminalization of health care.[3] All of these factors are then combined with the salary gap between PCPs and specialists and coupled with crippling medical school debt. All of these factors should be considered when proposing solutions.

While all these concerns must be addressed, none of the solutions will come quickly. The crisis is here now. Dr Snellings proposed to attract more physicians from internal medicine into primary care, but another significant portion of the health care workforce was overlooked. There are over 385,000 nurse practitioners (NPs) licensed to practice in the United States, with over 88% certified in primary care.[4] The outcomes among patients receiving primary care from NPs are similar to those receiving care from physicians and in some cases are also more cost effective.[5] NPs are kept from fulfilling the PCP gap because there are barriers in place preventing them from practicing to the full extent of their preparation.[6] Nearly half of the states in the United States. impose a reduced or restricted practice authority. Even among those states with full practice authority, several have imposed unnecessary transition-to-practice requirements, meaning that NPs must spend a period of time being supervised by a collaborating physician or NP, depending on the state, before they are able to practice independently to the full extent of their license. Further, NPs' own employers present restrictive barriers at the organizational level. Focusing efforts to remove unnecessary barriers to NPs practicing to their full scope, which is to practice independent of a physician, could deploy an immediate workforce in many sectors of health care, especially primary care.

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